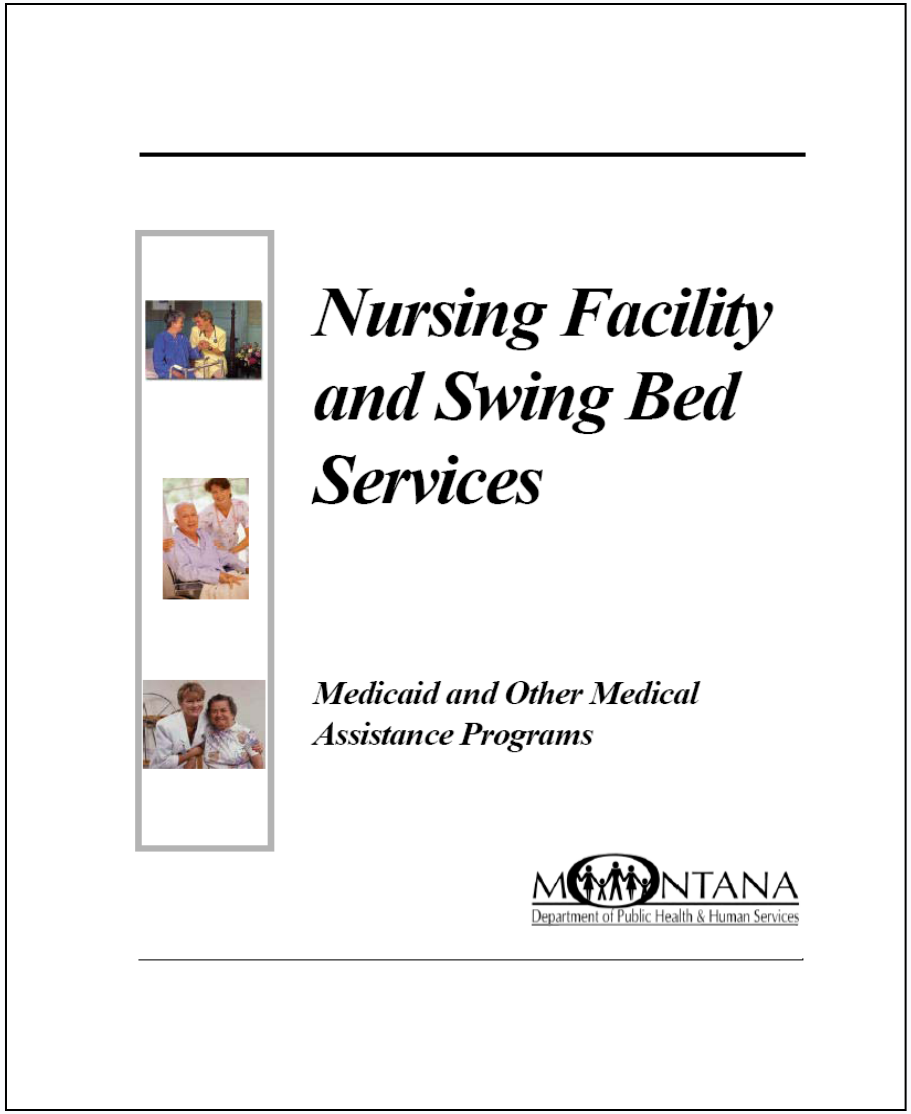
Department of Public Health and Human Services

Nursing Facility Services Bureau

Xerox WebEx Provider Training

Provider Manual

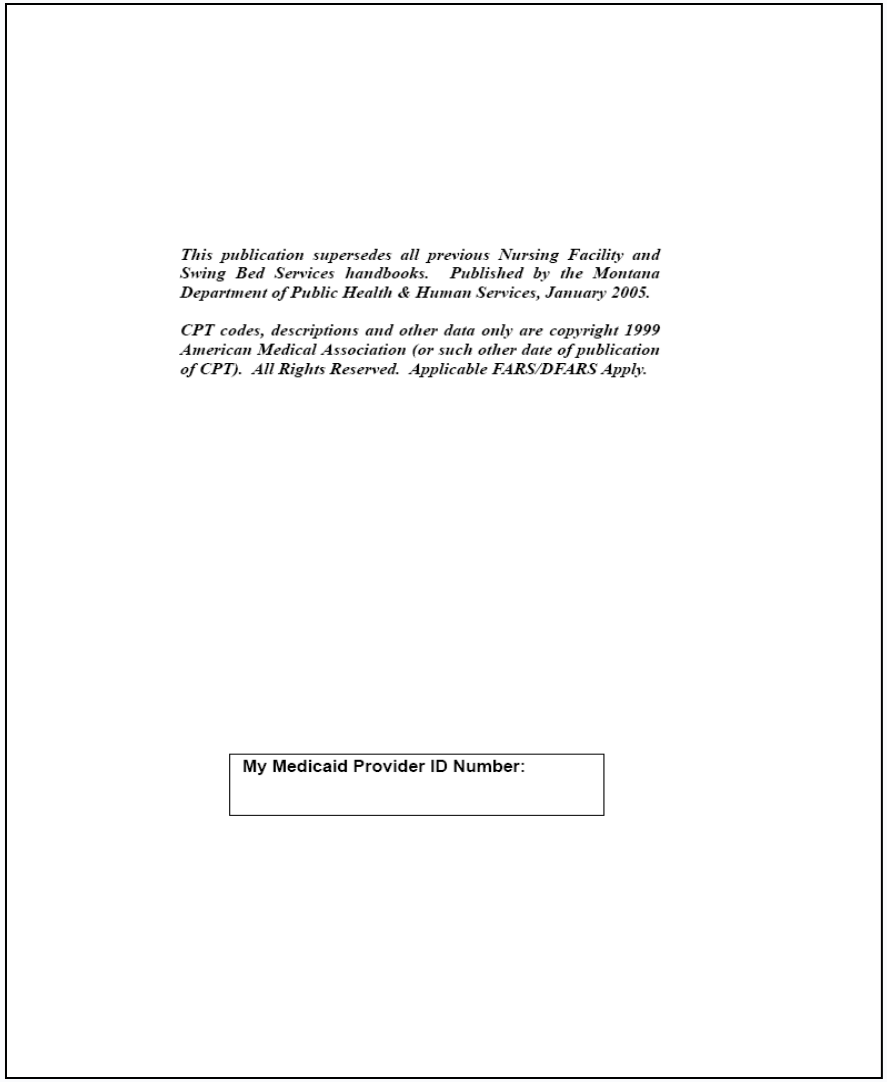
- **Available on the website www.mtmedicaid.org or http://medicaidprovider.hhs.mt.gov/**
- **Please make use of this resource**



NPI

National Provider Identifier

- This may also include a taxonomy number
- It is the number used on claims
- It is the number to use if a report or form for SLTC requires a provider #



This publication supersedes all previous Nursing Facility and Swing Bed Services handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

CPT codes, descriptions and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

My Medicaid Provider ID Number:

Resources Available on Web

www.mtmedicaid.org

- Provider Manuals
- Medicaid Rules/Regulations
- Fee Schedules
- Notices and Replacement Pages
- Other Resources
- Remittance Advice Notice
- Key Contacts

Provider Manuals

General Information For Providers

Medicaid billing manual with general information for all provider types.

Nursing Facility and Swing Bed Services

This manual has billing instructions specific to your provider type.

http://medicaidprovider.hhs.mt.gov/providerpages/providertype/26

Administrative Rules of Montana

http://www.mTRules.org/gateway/department.ASP?ID=18

Helpful hints for applying to Medicaid

http://www.dphhs.mt.gov/sltc/programs/Medicaid/IndexMedicaid.shtml

Resources Available on Web

Senior and Long Term Care

http://www.dphhs.mt.gov/sltc/index.shtml

- MDS 3.0 Sec Q
- Swing Beds
- Rate Setting
- Facility Medicaid Rates
- Direct Care Wage Program
- At Risk Payment Program (IGT)
- Level of Care (LOC)
- Medicaid Cost Report form and instructions

Claim Jumper on Web

http://medicaidprovider.hhs.mt.gov/providerpages/newsletters.shtml

- Please read the Claim Jumper EVERY month. It has important information for everyone.
- The Claim Jumper newsletter is only available on the website.

Contacts

MONTANA
Department of Public Health & Human Services

Key Contacts

ACS EDI Gateway, Inc.

For questions regarding electronic claims submission:

(800) 987-6719 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Mail to:
Montana EDI
ACS
P.O. Box 4936
Helena, MT 59604

Certification for Medical Need

Swing Bed Hospitals must obtain a certificate of need from the Quality Assurance Division in order to provide swing bed services.

(406) 444-2099 Phone

Send written inquiries to:
Quality Assurance Division
P.O. Box 202953
Helena, MT 59620-2953

Claims

Send paper claims to:
ACS Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information for Providers* manual.

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Drug Prior Authorization

For all questions regarding drug prior authorization:

(800) 395-7961
(406) 443-6002 6003? (Helena)
8:00 a.m. to 5:00 p.m., Monday–Friday
(Mountain Time)

Mail backup documentation to:
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Fax backup documentation to:
(800) 294-1350
(406) 443-7014 (Helena)

Fraud and Abuse

If you suspect fraud or abuse by an enrolled Medicaid client or provider, you may call one of the Program Compliance Bureau's fraud hotlines:

Client Eligibility Fraud
(800) 201-6308

Medicaid Client Help Line
(800) 362-8312

Lien and Estate Recovery

Providers must give any personal funds they are holding for a Medicaid-eligible resident to the Department within 30 days following the resident's death.

Phone:
(800) 694-3084 In-state
(406) 444-7313 Out-of-state and Helena

Fax:
(800) 457-1978 In-state
(406) 444-1829 Out-of-state and Helena

Send written inquiries to:
Third Party Liability Unit
Lien and Estate Recovery
DPHHS
P.O. Box 202953
Helena, MT 59620-2953

Nurse Aide Registry

To verify the nurse aide's certification status:

(406) 444-4980

Send written inquiries to:
Montana Nurse Aide Registry
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620

Point-of-Sale (POS) Help Desk

For assistance with online POS claims adjudication:
ACS, Atlanta
Technical POS Help Desk

(800) 365-4944
6:00 a.m to midnight, Monday–Saturday
10:00 a.m. to 9:00 p.m., Sunday,
(Eastern Time)

Preadmission Screening

For preadmission screening and level-of-care screening for clients entering a nursing facility or swing bed hospital, contact:

Phone:
(800) 219-7035 In and out-of-state
(406) 443-0320

Fax:
(800) 413-3890 In and out-of-state
(406) 443-4585

Send written inquiries to:
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the *General Information for Providers* manual.

Provider Relations

For questions about eligibility, payments, or denials, general claims questions, Passport, or to request provider manuals, fee schedules:

(800) 624-3958 In- and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send written inquiries to:
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Contacts

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Senior and Long-Term Care

Contact the Nursing Facility Services Bureau for the following:

- Nursing facility or swing bed program information
- Out-of-state nursing facility services
- Admission, transfer or discharge waivers
- Eligibility or claim issues that cannot be resolved through the county office of Public Assistance or Provider Relations
- Authorization for services described in the *Prior Authorization* chapter of this manual

(406) 444-4077 Phone
(406) 444-7743 Fax

Send written inquiries to:
Nursing Facility Services Bureau
Senior and Long-Term Care
P.O. Box 4210
Helena, MT 59604-4210

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In- and out-of-state
(406) 443-1365 Helena
(406) 442-0357 Fax

Send written inquiries to:
ACS Third Party Liability Unit
P.O. Box 5838
Helena, MT 59604

Level of Care Screenings

Mountain-Pacific Quality Health

- Level of care determinations must be completed by Mountain Pacific Quality Health for all residents meeting all level of care criteria.
- If you have any questions on LOC(s), please contact Mountain Pacific Quality Health at 443-0320 or 1-800-219-7035.
- The facility SHOULD make sure it completes a level of care screening. The LOC is the equivalent of your prior authorization (or determination of medical necessity) for Nursing Facility Services. WITHOUT the level of care screening a nursing home span WILL NOT be opened and your claims will not be paid.
- Clearly some residents are not Medicaid eligible and the facility should not complete inappropriate screenings to MPQH on non-Medicaid residents upon admissions.
- The LOC is the equivalent of a prior authorization (or determination of medical necessity) for Nursing Facility Services under Medicaid.
- Here is a link to information on LOC screens
  http://www.dphhs.mt.gov/sltc/services/nursingfacilities/LOC.shtml

PAYMENT ERROR RATE MEASUREMENT (PERM)

The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, CMS developed the Payment Error Rate Measurement (PERM) program to comply with IPIA and related guidance issued by OMB. (CMS.GOV)

The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The error rates are based on reviews of the fee-for-services (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. It is important to note the error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements. FY 2008 was the first year in which CMS reported error rates for each component of the PERM program. (CMS.GOV)

- STARTING THIS FALL (FY2014) SOME NURSING FACILITES WILL BE RANDOMLY SELECTED FOR A PERM AUDIT.
- THE FEDERAL GOVEMNMENT REQUIRES PAYMENT BACK FROM THE STATE FOR NURSING FACILITY CLAIMS THAT ARE FOUND NOT TO BE IN COMPLIANCE WITH REGULATIONS/RULES.
- THE STATE OF MONTANA WILL THEN REQUEST THE PAYMENT BACK FROM THE NURSING FACILITY.
- WHEN YOUR FACILITY IS NOTIFIED OF A PERM AUDIT MAKE SURE YOU SUBMIT TO THE AUDITORS THE APPROPRIATE SUPPORTING DOCUMENTION.

FY2011 PERM FINDINGS

- ✓ THE FY 2011 PERM AUDIT FOR NURSING FACILITIES REPORTED A NON COMPLIANCE WITH PHYSICIAN PROGRESS NOTES AND FREQUENCY OF PHYSICIAN VISITS.
- ✓ THE ONON-COMPLIANCE WAS DUE TO NO SUPPORTING DOCUMENTATION.
- ✓ FACILITES MUST BE IN COMPLIANCE WITH 42 CFR 483.40

(b) Physician visits. The physician must—

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

(2) Write, sign, and date progress notes at each visit; and

(3) Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

(c) Frequency of physician visits. (1) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

(4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section.

Medicaid Eligibility

Medicaid eligibility determination is a separate process of **financial eligibility** determination.

Sometimes the eligibility determination is hindered by the resident/family/authorized representative because of timeliness, incomplete applications, documentation, etc. The facility should notify the resident, etc. that without Medicaid they will be private pay.

As part of its admission procedures the Nursing Facility SHOULD

- ASK the family or authorized representative and learn whether the resident has adequate means to pay the facility or ask them if they plan on applying for Medicaid.
- HAVE a supply of Medicaid applications on file to provide to the family.

The applications can be found on-line at,

http://www.dphhs.mt.gov/programsservices/publicassistanceprograms.shtml

The facility should follow up with the resident/residents' authorized representatives if the Medicaid determination is being delayed by information not being supplied to the Medicaid case worker.

Remember there may be a portion of resident's care which must be paid by the resident.

OPA

- The local Office of Public Assistance (OPA) is there to provide information about the eligibility process and what information is needed to help avoid delays and to streamline the eligibility process.
- If an applicant / resident feels that they may need Medicaid's help to cover the costs of nursing facility care, the local Office of Public Assistance (OPA) should be contacted AS SOON AS POSSIBLE to speak to a case manager and begin filling out an application.
- OPA encourages facilities to form a relationship between facility staff and the Medicaid office. Set up a meeting between your business office staff and the Medicaid case workers. Discuss issues that each see and ways to resolve them. Agree upon standard operating and communication procedures.
- Learn the chain of command at your local Medicaid office. If you are not seeing timely responses or actions from a worker (either in general or on a given case), contact that person's supervisor for more information. If necessary, continue to engage the chain of contact to the county director, and then to the Central Office of Public Assistance Bureau.
- Local OPA offices can be found at:
  http://www.dphhs.mt.gov/contactus/humancommunityservices.shtml
- Be sure to have resident complete DPHHS Form No. HPS-402: AUTHORIZATION "For the Use and Disclosure of Health Information " to allow a facility to secure information from County Office.

Monthly Nursing Facility Staffing Report

- **Electronic version of form is available contact me at bmcanally@mt.gov**
- **Facility is required by the 10th of every month for previous month's data**
- **Tracks staffing trends**
- **Enter direct care hours and actual number of people working those hours**
- **Bed days by level of care and payment source**
- **Used in Medicaid budgeting process as a method of projecting Medicaid utilization**

MONTHLY NURSING HOME STAFFING REPORT

MONTANA STATE DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
Nursing Facility Services Bureau
PO Box 4210
Helena, MT 59604-4210
Phone 406-444-4077 FAX 406-444-7743

FACILITY NAME: _____ **Provider #** _____

FACILITY ADDRESS: _____ **City** _____

MONTH ENDING: _____

STAFFING REQUIREMENT: Facilities must provide staffing at levels which are adequate to meet federal law, regulations and requirements.

HOURS/EMPLOYEES DURING REPORTING PERIOD:
Please list the total number of hours worked and number of employees in each of the listed categories for the month:

	TOTAL EMPLOYEE HOURS	TOTAL CONTRACT HOURS	TOTAL HOURS WORKED
RN'S			
LPN'S			
CNA / AIDES:			
TOTAL			

	NUMBER OF FACILITY EMPLOYEES	NUMBER OF CONTRACT STAFF	TOTAL NUMBER OF RN, LPN, CNA
RN'S			
LPN'S			
CNA / AIDES:			
TOTAL			

Note: Include all RN, LPN and AIDE hours for direct care staff. Director of Nursing hours may be included if spent dispensing meds, on rounds or charting - do not include administrative hours. Do not include time spent on in-service training, time for laundry or maintenance staff even if they are certified as aides or other non-direct care staff. Contract employees / hours are direct care hours provided by agency staff, temp. service staff, etc. who are not employees of the facility.

PATIENT DAYS:
Please list the total number of occupied days by each category for the month:

LEVEL OF CARE	MEDICAID	MEDICARE	LONG TERM CARE INSURANCE	VETERANS	PRIVATE PAY	OTHER (Work Comp Ins., Auto Ins, Medigap Ins, etc)	TOTAL
Skilled Care (SNF)							
Nursing Care (NF)							
Hospice							
Billable Bed Holds							
Other							
TOTAL (5 rows)							
Medicare Co-Insurance Payments (duplicated)							

CERTIFICATION:
I certify that this information, to the best of my knowledge, is true, accurate, and complete:

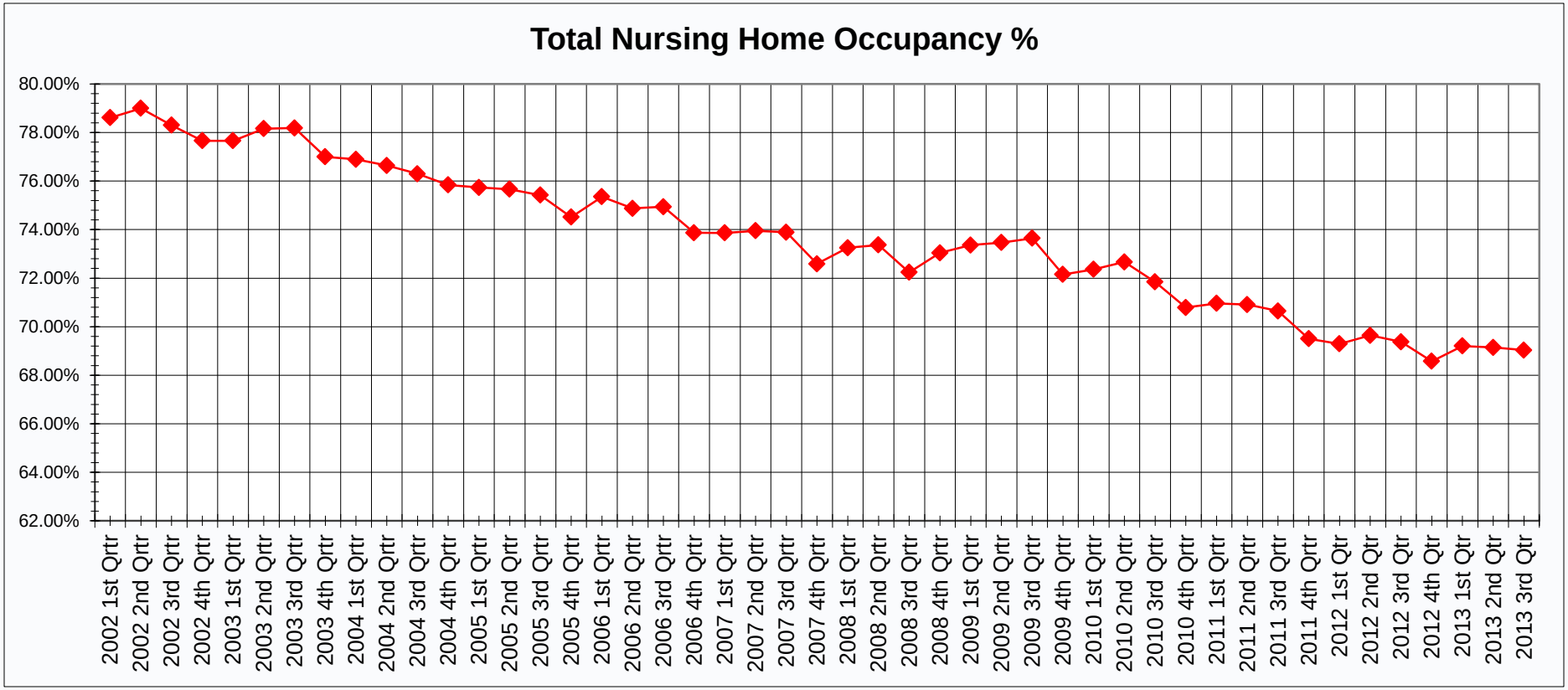
Signed: _____ Title: _____

Date: _____
MAIL THIS FORM TO: SENIOR AND LONG TERM CARE DIVISION, PO BOX 4210, HELENA, MT 59604-4210
TIME LINE: This form is to be submitted to the department within 10 days following the end of each calendar month.

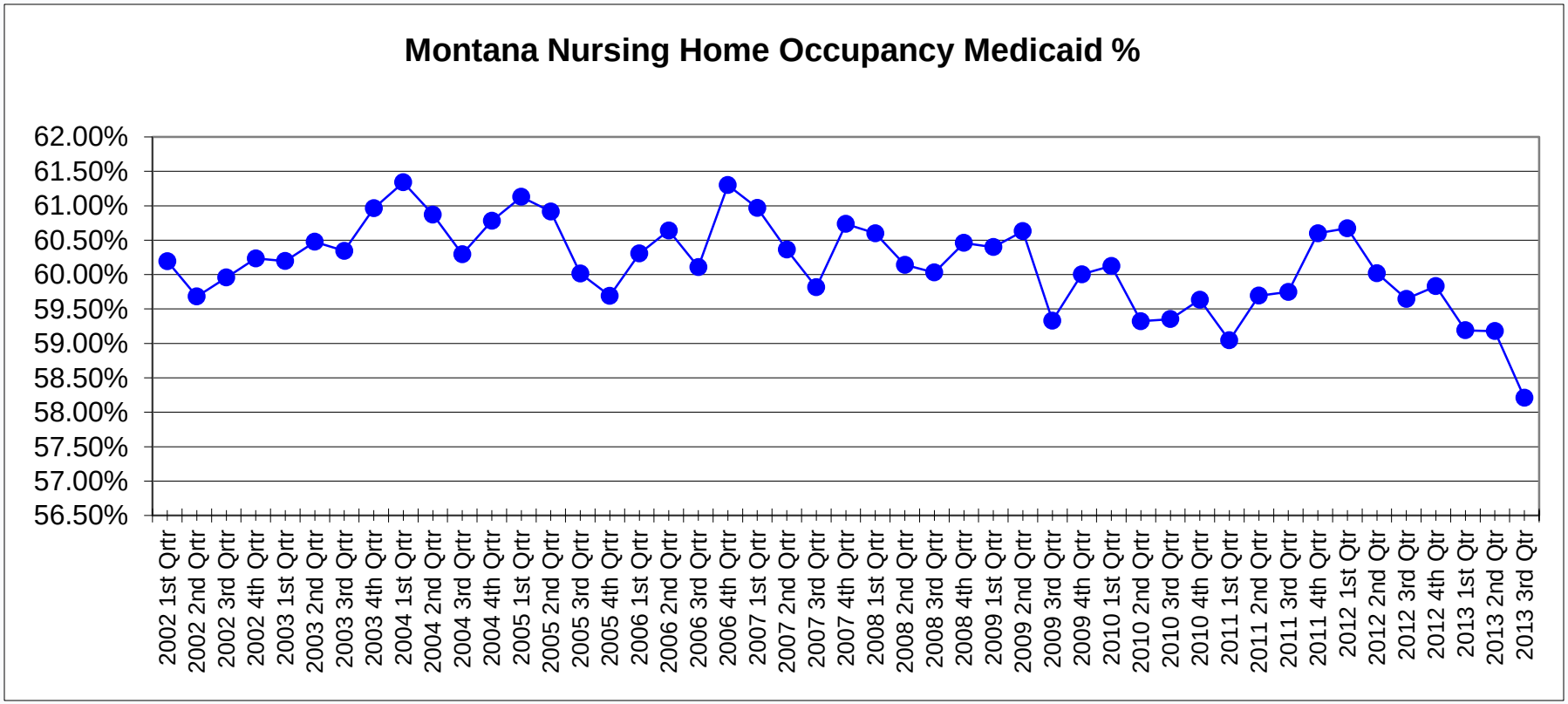
Instructions for Staffing Reports

- Check our website at www.medicaidprovider.hhs.mt.gov and click on the Nursing Facility and Swing Bed Services.
- Any questions, please contact Becky McAnally 406-444-3997 or email me at bmcanally@mt.gov.

Total Nursing Facility Occupancy



Average Medicaid Occupancy



CNA Training & Testing Report

- **Quarterly report due within 1st month after quarter ends**

  July – Sept due in October

  Oct – Dec due in January

  Jan – March due in April

  April – June due in July

- **Initial Certification T&T only**

- **Facilities are reimbursed thru the Medicaid per diem rate – no separate funding available.**

- **We collect data to meet Federal Medicaid Reporting requirements.**

- **If the facility has no activity for that quarter, this report must be submitted reporting as "No Activity".**

- **If you have any questions on the C.N.A. Training & Testing program information , please visit this website: http://www.dphhs.mt.gov/sltc/services/nursingfacilities/index.shtml**

Sample Only

First Quarter FY 2005 Costs (July 1, 2004 through September 30, 2004)

Please return completed form by **November 1, 2004** to:

Lucinda Fleming, Human Services Specialist
Senior and Long Term Care Division
Department of Public Health and Human Services
P.O. Box 4210
Helena, MT 59604-4210

EFFECTIVE JULY 1, 1998 TESTING FEES PAID TO HEADMASTER WILL BE INCLUDED ON THIS FORM.

CATEGORY	AMOUNT	DESCRIPTION
1. Supplies and Equipment:	$	
2. Facility Personnel:	$	
3. Sub-Contracted Services:	$	
4. Number of CNAs Trained During Quarter:		
5. Competency Evaluation Testing	$	
6. Number of CNAs tested during Quarter:		
Signature of Administrator:		
Facility:		
Facility Medicaid Provider #	City:	

ARM 37.40.322 (2)(b) states "if a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments in accordance with ARM 37.40.346 (4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form."

Bed Hold Days

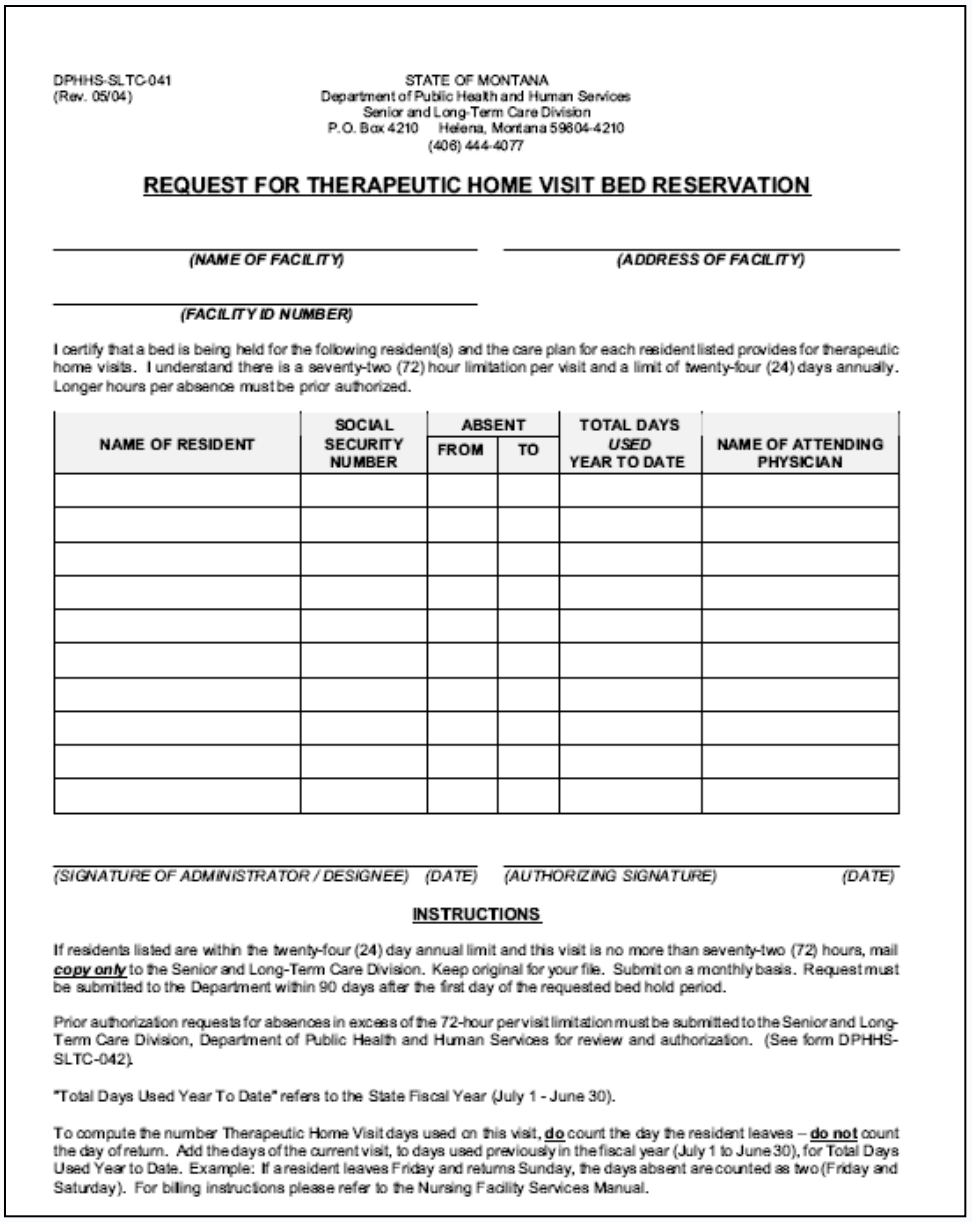
Covered by ARM 37.40.338

- Therapeutic Home Visits Less Than 72 Hours
  - Form DPHHS-SLTC-041
- Therapeutic Home Visits Greater Than 72 Hrs
  - Form DPHHS-SLTC-042
- Hospital Holds
  - Form DPHHS-SLTC-052

If you need more of these forms, then please email Becky @ bmcanally@mt.gov.

Therapeutic Home Visit (THV) Less than 72 Hour

- **Form DPHHS-SLTC-041**
- **<u>Does not</u> require prior authorization**
- **Please submit this form monthly**
- **More than one resident per form**
- **The form cannot be submitted later than 90 days of the 1st day of the requested bed hold reservation (THV) on the form**
- **Do Not continue to reflect residents reports in previous months.**



DPHHS-SLTC-041
(Rev. 05/04)

STATE OF MONTANA
Department of Public Health and Human Services
Senior and Long-Term Care Division
P.O. Box 4210 Helena, Montana 59604-4210
(406) 444-4077

REQUEST FOR THERAPEUTIC HOME VISIT BED RESERVATION

(NAME OF FACILITY) *(ADDRESS OF FACILITY)*

(FACILITY ID NUMBER)

I certify that a bed is being held for the following resident(s) and the care plan for each resident listed provides for therapeutic home visits. I understand there is a seventy-two (72) hour limitation per visit and a limit of twenty-four (24) days annually. Longer hours per absence must be prior authorized.

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	ABSENT FROM	ABSENT TO	TOTAL DAYS *USED* YEAR TO DATE	NAME OF ATTENDING PHYSICIAN

(SIGNATURE OF ADMINISTRATOR / DESIGNEE) *(DATE)* *(AUTHORIZING SIGNATURE)* *(DATE)*

INSTRUCTIONS

If residents listed are within the twenty-four (24) day annual limit and this visit is no more than seventy-two (72) hours, mail ***<u>copy only</u>*** to the Senior and Long-Term Care Division. Keep original for your file. Submit on a monthly basis. Request must be submitted to the Department within 90 days after the first day of the requested bed hold period.

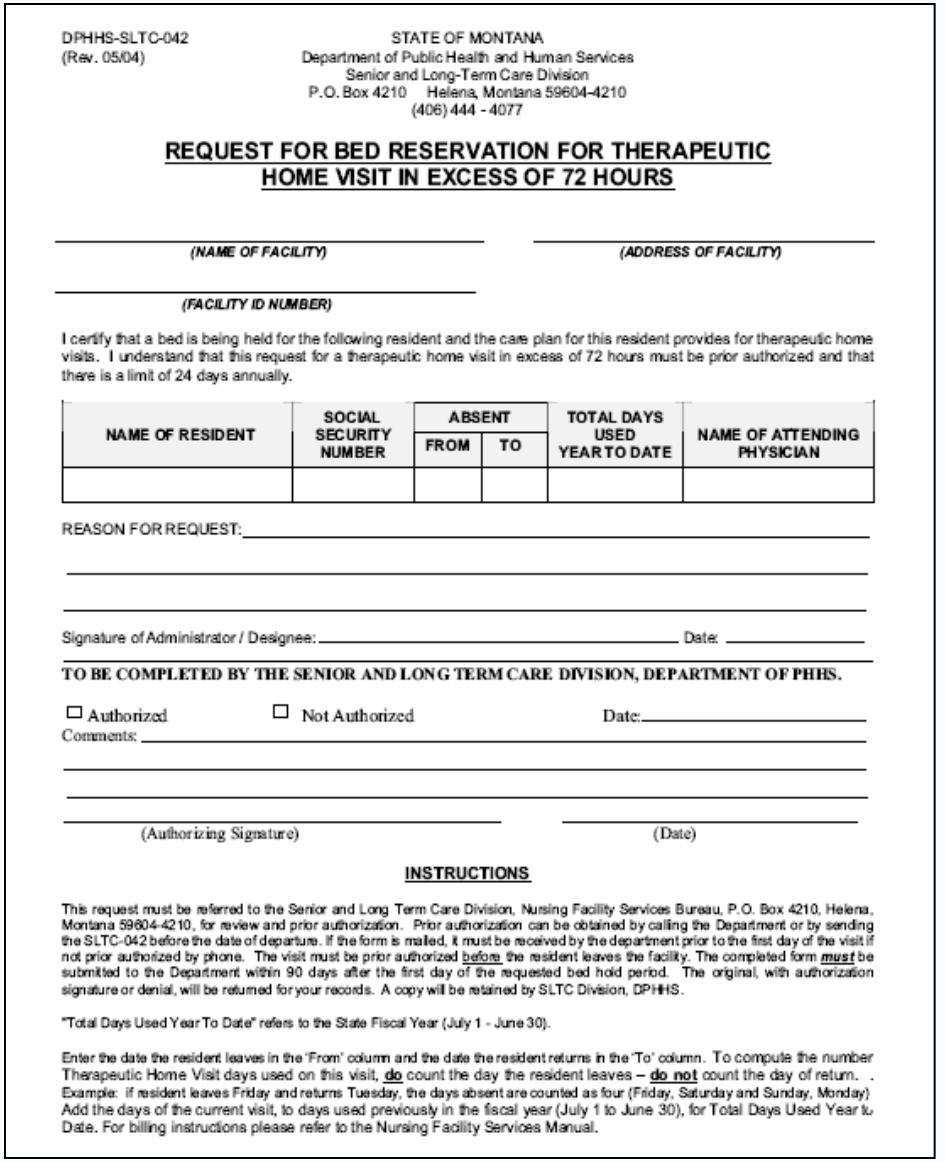
Prior authorization requests for absences in excess of the 72-hour per visit limitation must be submitted to the Senior and Long-Term Care Division, Department of Public Health and Human Services for review and authorization. (See form DPHHS-SLTC-042).

"Total Days Used Year To Date" refers to the State Fiscal Year (July 1 - June 30).

To compute the number Therapeutic Home Visit days used on this visit, **<u>do</u>** count the day the resident leaves – **<u>do not</u>** count the day of return. Add the days of the current visit, to days used previously in the fiscal year (July 1 to June 30), for Total Days Used Year to Date. Example: If a resident leaves Friday and returns Sunday, the days absent are counted as two (Friday and Saturday). For billing instructions please refer to the Nursing Facility Services Manual.

Therapeutic Home Visit (THV) in excess of 72 hours

- **Form DPHHS-SLTC-042**
- **<u>Does</u> require Prior Authorization <u>Before</u> resident leaves facility**
- **Request must be submitted to SLTC for review and prior authorization – call 406-444-3997 or fax 406-444-7743**
- **Must be on care plan that extended visits are appropriate, and the resident's doctor must approve the resident to leave the facility**
- **After prior authorization is approved, the form must be submitted within 90 days of the 1st day of the requested bed reservation period.**



DPHHS-SLTC-042
(Rev. 05/04)

STATE OF MONTANA
Department of Public Health and Human Services
Senior and Long-Term Care Division
P.O. Box 4210 Helena, Montana 59604-4210
(406) 444 - 4077

REQUEST FOR BED RESERVATION FOR THERAPEUTIC HOME VISIT IN EXCESS OF 72 HOURS

_____ _____
(NAME OF FACILITY) *(ADDRESS OF FACILITY)*

_____
(FACILITY ID NUMBER)

I certify that a bed is being held for the following resident and the care plan for this resident provides for therapeutic home visits. I understand that this request for a therapeutic home visit in excess of 72 hours must be prior authorized and that there is a limit of 24 days annually.

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	ABSENT		TOTAL DAYS USED YEAR TO DATE	NAME OF ATTENDING PHYSICIAN
		FROM	TO		

REASON FOR REQUEST: _____

Signature of Administrator / Designee: _____ Date: _____

TO BE COMPLETED BY THE SENIOR AND LONG TERM CARE DIVISION, DEPARTMENT OF PHHS.

☐ Authorized ☐ Not Authorized Date: _____

Comments: _____

_____ _____
(Authorizing Signature) (Date)

INSTRUCTIONS

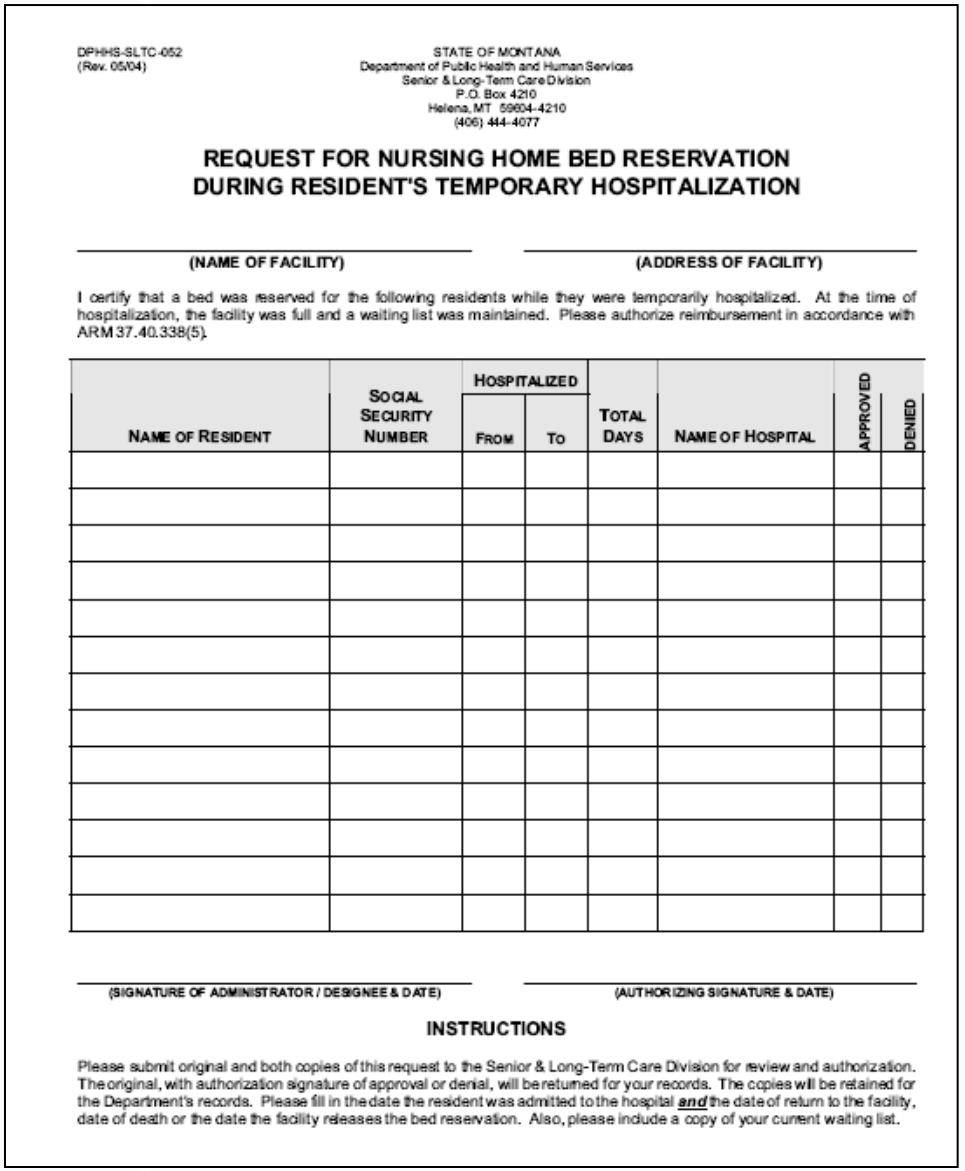
This request must be referred to the Senior and Long Term Care Division, Nursing Facility Services Bureau, P.O. Box 4210, Helena, Montana 59604-4210, for review and prior authorization. Prior authorization can be obtained by calling the Department or by sending the SLTC-042 before the date of departure. If the form is mailed, it must be received by the department prior to the first day of the visit if not prior authorized by phone. The visit must be prior authorized before the resident leaves the facility. The completed form ***must*** be submitted to the Department within 90 days after the first day of the requested bed hold period. The original, with authorization signature or denial, will be returned for your records. A copy will be retained by SLTC Division, DPHHS.

"Total Days Used Year To Date" refers to the State Fiscal Year (July 1 - June 30).

Enter the date the resident leaves in the 'From' column and the date the resident returns in the 'To' column. To compute the number Therapeutic Home Visit days used on this visit, **do** count the day the resident leaves – **do not** count the day of return. . Example: if resident leaves Friday and returns Tuesday, the days absent are counted as four (Friday, Saturday and Sunday, Monday) Add the days of the current visit, to days used previously in the fiscal year (July 1 to June 30), for Total Days Used Year to Date. For billing instructions please refer to the Nursing Facility Services Manual.

Hospital Hold

- **Form DPHHS-SLTC-052**
- **Request must be submitted to SLTC for review and authorization**
- **Facility must be full with waiting list to be reimbursed for Hospital Hold by Medicaid**
- **Form must be received within 90 days of 1st day of hospitalization with attached Nursing Facility waiting list for that period of hospitalization**
- **SLTC will use Monthly Staffing Reports as a check for full capacity**



DPHHS-SLTC-052
(Rev. 05/04)

STATE OF MONTANA
Department of Public Health and Human Services
Senior & Long-Term Care Division
P.O. Box 4210
Helena, MT 59604-4210
(406) 444-4077

REQUEST FOR NURSING HOME BED RESERVATION DURING RESIDENT'S TEMPORARY HOSPITALIZATION

(NAME OF FACILITY) _____ (ADDRESS OF FACILITY) _____

I certify that a bed was reserved for the following residents while they were temporarily hospitalized. At the time of hospitalization, the facility was full and a waiting list was maintained. Please authorize reimbursement in accordance with ARM 37.40.338(5).

NAME OF RESIDENT	SOCIAL SECURITY NUMBER	HOSPITALIZED		TOTAL DAYS	NAME OF HOSPITAL	APPROVED	DENIED
		FROM	TO				

(SIGNATURE OF ADMINISTRATOR / DESIGNEE & DATE) _____ (AUTHORIZING SIGNATURE & DATE) _____

INSTRUCTIONS

Please submit original and both copies of this request to the Senior & Long-Term Care Division for review and authorization. The original, with authorization signature of approval or denial, will be returned for your records. The copies will be retained for the Department's records. Please fill in the date the resident was admitted to the hospital ***and*** the date of return to the facility, date of death or the date the facility releases the bed reservation. Also, please include a copy of your current waiting list.

Swing Bed Providers

- Administrative Rules of Montana at 37.40.401-421. pertain to the Medicaid requirements and payments for services in Swing Bed Hospitals.
- Be a licensed hospital, Licensed Medical Assistance Facility (MAF) or Critical Access Hospital (CAH), which is Medicare certified to provide swing bed services
- Enroll as a Medicaid swing bed hospital provider
- Be located in a rural area of the state

Swing Bed Providers Admission Requirements

- Swing beds are to be used only when there is no appropriate nursing facility bed available, within a 25 mile radius of the swing bed hospital that can meet the resident's needs.
- Swing bed hospitals & CAH must canvas all of the nursing facilities within the 25-mile radius to determine the availability of an appropriate nursing facility bed prior to admission of the individual to the swing bed.
- Swing bed hospital & CAH must include in medical record documentation that supports that no nursing facility bed was available in order to document the appropriateness of the admission into the swing bed and the billing to Medicaid.
- Medicaid recipient must meet level of care requirements based on screening completed by the Mountain Pacific Quality Health.

Swing Bed Transfer Requirements

A swing bed Medicaid recipient must be discharged to an appropriate nursing facility bed within the 25-mile radius of the swing bed facility once a nursing facility bed becomes available.

Swing Bed Provider Waiver of Transfer Requirement

- Physician may request in writing a waiver of the 25 mile transfer requirement if;
- The recipient's condition would be endangered by the transfer to an appropriate nursing facility bed, or
- The individual has a medical prognosis or terminal condition where by his/her life expectancy is six months or less.
- Senior and Long Term Care Division evaluate this information and will either approve or deny this request for a waiver in writing to the swing bed hospital or CAH.
- For waiver of the transfer requirements contact Becky McAnally at 406-444-3997.

Swing Bed Providers Billing

- Swing bed providers bill the per diem rate established by Medicaid on the Form MA-3.

- Beginning March 4, 2010 swing bed facilities may now bill Montana Medicaid electronically for per diem charges. Services that are included in the swing bed per diem rate and the services that can be billed in addition to the per diem are the same as for nursing facility providers.

Claims

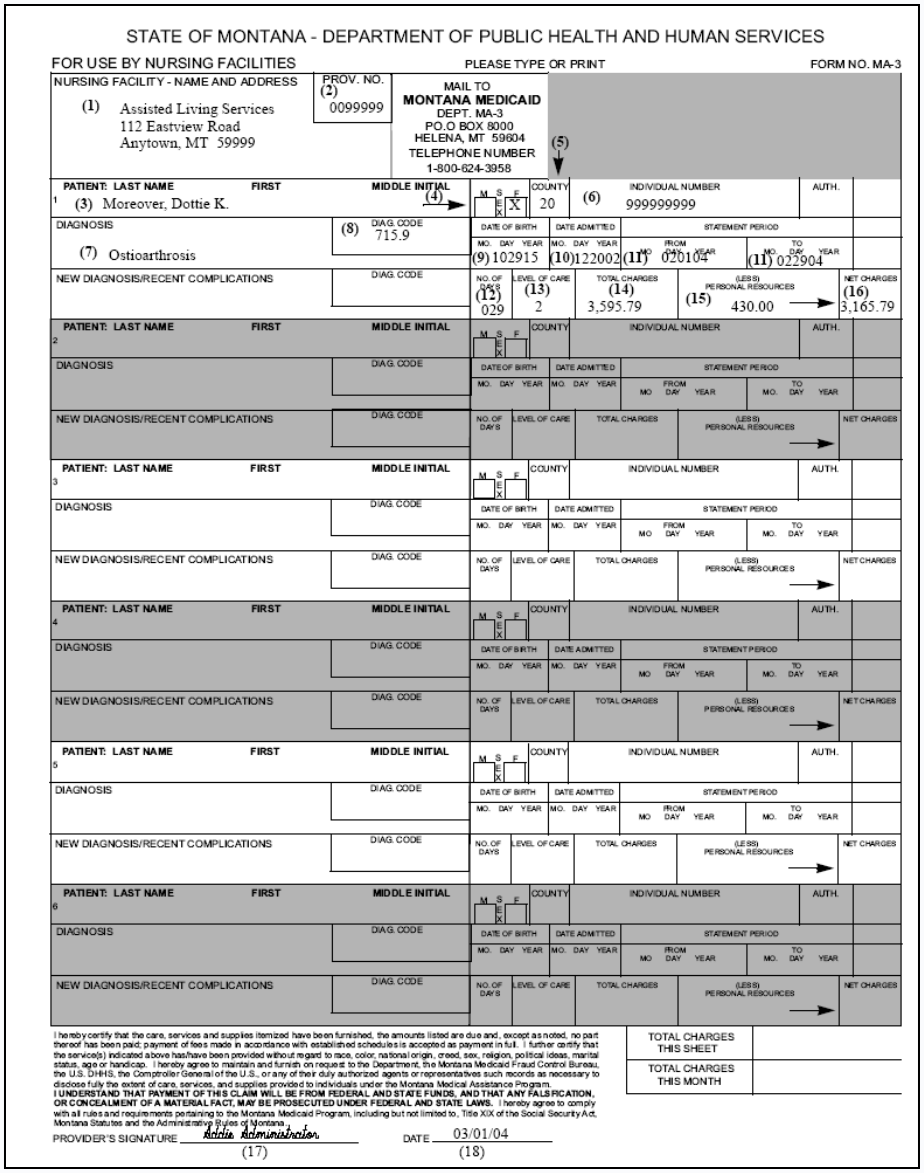
- All **Paper** NF claims submitted on an MA-3 or a CMS 1500
- Paper claims and TADs (turn around documents) require manual input at several points in the claims process.
- Electronic claims generally only require manual input at one point – THEREFORE – electronic claims are less likely to be inaccurate due to human error .
- Electronic claims filing will be required in the new MMIS system.
- There may be a learning curve with electronic claims - but once that is past – electronic claims are generally faster and more accurate. When there are errors, there are more opportunities *(weekly billing is an option)* to correct the errors within timely filing limits (365 days)
- If EFT (Electronic Funds Transfer) is also selected then the payment does not have to wait for the check printing cycle.

TADS (Turn Around Documents)

- TADs are a system generated MA-3 – based on the paper claims submitted in the previous month.
- These are provided to expedite billing for Nursing Facilities but should not be assumed to be accurate.
- Nursing Facility personnel need to review the documents for accuracy – if a resident was not in the facility the previous month, he or she will have to be added. If a resident left the facility the number of days may need to be changed or the resident may need to be deleted from the document if discharged or expired.
- If a resident was not in the facility a full month the previous month or had a different personal resource amount those differences will be on the TAD and will need to be updated.
- Coding numbers change from time to time and just because the diagnosis code (for instance) was accurate last month it does not mean that it is accurate this month.

Claims Accuracy

- **Submit claims promptly**
- **From and To dates -use the dates being claimed**
- **The cleaner your submission the better the system works**



STATE OF MONTANA - DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

FOR USE BY NURSING FACILITIES — PLEASE TYPE OR PRINT — FORM NO. MA-3

NURSING FACILITY - NAME AND ADDRESS
(1) Assisted Living Services
112 Eastview Road
Anytown, MT 59999

PROV. NO. (2) 0099999

MAIL TO
MONTANA MEDICAID
DEPT. MA-3
PO.O BOX 8000
HELENA, MT 59604
TELEPHONE NUMBER
1-800-624-3958

(5)

PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	(4)	M	S	F	COUNTY	(6) INDIVIDUAL NUMBER	AUTH.
1 (3) Moreover,	Dottie	K.				X	20	999999999	

DIAGNOSIS	(8) DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)
(7) Ostioarthrosis	715.9	(9) 102915	(10) 122002	(11) 020104	(11) 022904

NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	(12) NO. OF DAYS	(13) LEVEL OF CARE	(14) TOTAL CHARGES	(15) (LESS) PERSONAL RESOURCES	(16) NET CHARGES
		029	2	3,595.79	430.00	3,165.79

PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	M	S	F	COUNTY	INDIVIDUAL NUMBER	AUTH.
2								

DIAGNOSIS	DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)

NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES	NET CHARGES

PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	M	S	F	COUNTY	INDIVIDUAL NUMBER	AUTH.
3								

DIAGNOSIS	DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)

NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES	NET CHARGES

PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	M	S	F	COUNTY	INDIVIDUAL NUMBER	AUTH.
4								

DIAGNOSIS	DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)

NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES	NET CHARGES

PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	M	S	F	COUNTY	INDIVIDUAL NUMBER	AUTH.
5								

DIAGNOSIS	DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)

NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES	NET CHARGES

PATIENT: LAST NAME	FIRST	MIDDLE INITIAL	M	S	F	COUNTY	INDIVIDUAL NUMBER	AUTH.
6								

DIAGNOSIS	DIAG. CODE	DATE OF BIRTH (MO. DAY YEAR)	DATE ADMITTED (MO. DAY YEAR)	STATEMENT PERIOD FROM (MO DAY YEAR)	STATEMENT PERIOD TO (MO. DAY YEAR)

NEW DIAGNOSIS/RECENT COMPLICATIONS	DIAG. CODE	NO. OF DAYS	LEVEL OF CARE	TOTAL CHARGES	(LESS) PERSONAL RESOURCES	NET CHARGES

I hereby certify that the care, services and supplies itemized have been furnished, the amounts listed are due and, except as noted, no part thereof has been paid; payment of fees made in accordance with established schedules is accepted as payment in full. I further certify that the service(s) indicated above has/have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap. I hereby agree to maintain and furnish on request to the Department, the Montana Medicaid Fraud Control Bureau, the U.S. DHHS, the Comptroller General of the U.S., or any of their duly authorized agents or representatives such records as necessary to disclose fully the extent of care, services, and supplies provided to individuals under the Montana Medical Assistance Program.
I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS. I hereby agree to comply with all rules and requirements pertaining to the Montana Medicaid Program, including but not limited to, Title XIX of the Social Security Act, Montana Statutes and the Administrative Rules of Montana.

PROVIDER'S SIGNATURE Admin. Administrator (17) DATE 03/01/04 (18)

TOTAL CHARGES THIS SHEET	
TOTAL CHARGES THIS MONTH	

Separately Billable Items i.e. Ancillary Items

- Billed on **CMS 1500**
- Fee schedule is a list of items which are separately billable and the codes to use. You can find the fee schedule at this website www.medicaidprovider.hhs.mt.gov.
- Billable at acquisition cost with no markup, i.e. Ancillary Items. ARM site 37.40.330
- Some items may be billable for nursing facility residents by other provider types (DME, Therapy, Pharmacy)

Prior Authorizations

Required for following services

- ARM 37.85.205 & 37.86.5101 - 5120
- Feeding solutions
  - When sole source of nutrition (Medicare may also pay – so Medicare Explanation of Benefits (EOB may be required) Medicaid may pay when it is primary source of nutrition
- Routine Supplies used in extraordinary amounts
- Oxygen Concentrators

All require Doctor's orders and documentation of cost

Claims Problem Resolution

Denied Claims –

Check Error Codes and correct claims – some issues are:

- Eligibility issues:
  - Verify that dates being claimed are within an eligibility span. There are a number of ways to check eligibility. Medicaid card, Provider Web portal, and Fax back as examples.
  - If unable to confirm eligibility and resident claims eligibility check with County OPA

Claims Problem Resolution

Denied Claims –

Check Error Codes and correct claims – some issues are:

- No NH span –
  make sure dates are entered correctly change if appropriate
  If dates are correct – check with county office as to dates on NH span
  If county office says the span has been entered and dates agree with your dates - if claim denies the next month call Provider Relations.
  If claims continue to deny - call SLTC
- Diagnosis Code
  If code has been used previously make sure there has not been a coding change. Use the most specific code available

Claims Problem Resolution

- **Claims paid incorrectly**
  - **Paid claims must be adjusted – do not submit a new claim to adjust an already paid claim**
  - **Use the adjustment form to submit an adjustment**
    - **Fill in top box completely**
    - **Fill in only info being changed in the bottom**
  - **Claims and adjustments must be completed within 365 days of dates of service**

Updated 04/2011

Montana Health Care Programs

Medicaid • Mental Health Services Plan • Healthy Montana Kids

Individual Adjustment Request

Instructions:
This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name & Address
   Name
   Street or P.O. Box
   City State ZIP
2. Client Name
3. Internal Control Number (ICN)
4. NPI/API
5. Client ID Number
6. Date of Payment
7. Amount of Payment $

B. Complete only the items which need to be corrected.

	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service			
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature: _____ Date: _____

When the form is complete, attach a copy of the RA and a copy of the corrected claim.

MONTANA Department of Public Health & Human Services

Mail to: ACS
P.O. Box 8000
Helena, MT 59604

ACS A xerox Company

Tips to Avoid Timely Filing Denials

- **Submit claims in a timely manner.**
- **Correct and resubmit denied claims promptly Some areas to watch for include the following:**
- **Ensure coding is correct and valid for your provider type**
- **Make sure the dates of service are the days being claimed.**
- **Confirm that the resident's Medicaid ID number is correct**
- **If a claim continues to deny, contact Provider Relations for assistance in resolving the claim (see *Key Contacts*).**
- **If a provider has made several attempts to resolve a claim including working with Provider Relations and the provider believes that the claim is a clean claim, and it still denies, contact Senior and Long Term Care for review of the claim (see Key Contacts).**
- **Under very limited circumstances, providers may need to submit an adjustment for a claim over 365 days from the date of service. In these cases, submit the claim to Senior and Long Term Care for review and special handling.**
- **If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status (see *Key Contacts*).**

SLTC CONTACTS

BUREAU CHIEF: RICK NORINE - 406-444-4209 or email rnorine@mt.gov

Rick is responsible for the overall management and coordination of the Medicaid nursing facility program including policy, reimbursement and program development. The Bureau Chief acts as the supervisor for the following positions: Institutional Superintendent of Montana Veterans Home, two Human Services Specialists, and an Administrative Officer at Eastern Montana Veterans Home.

HUMAN SERVICES SPECIALIST : STEVE BLAZINA - 406-444-4129 or e-mail sblazina@mt.gov

Steve sets the Nursing Facility Medicaid Per Diem Rates and the Medicaid Swing Bed Per Diem Rates for Hospital and Critical Access Hospital Providers. He maintains the Medicaid Nursing Facility Cost Reports for each fiscal year.

HUMAN SERVICES SPECIALIST : Becky McAnally - 406-444-3997 or e-mail bmcanally@mt.gov

Becky is responsible for prior authorizations on therapeutic home visits, enteral and parenteral feeding solution, and extraordinary use of routine supplies. Becky is also responsible for nursing facility problem claim reviews, and the monitoring and verification of the following nursing facility reporting requirements:

- ✓ Monthly Nursing Home Staffing Report (DPHHS-SLTC-015)
- ✓ Request for Nursing Home Bed Reservation During Resident's Temporary Hospitalization (DPHHS-SLTC-052)
- ✓ Request for Therapeutic Home Visit Bed Reservation (DPHHS-SLTC-041)
- ✓ Request for Bed Reservation for Therapeutic Home Visit in Excess of 72 Hours (DPHHS-SLTC-042)

Quarterly Nurse Aide Certification/Training and Competency Evaluation Survey Form

QUESTIONS?